

Employment Practices Liability Insurance

CLAIMS MADE WARNING FOR APPLICATION

THIS PROPOSAL FORM IS FOR A CLAIMS MADE POLICY, RELATING TO CLAIMS MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD OR EXTENDED REPORTING PERIOD, IF APPLICABLE.

Whenever printed in this Proposal Form, the terms in boldface type shall have the same meanings as indicated in the Policy. This Proposal Form is to be completed with respect to the entire Insured Entity. **Insured Entity** as used herein is defined to include the **Named Insured** and any **Subsidiaries**.

Name of **Named Insured**

Street Address Suite

City State Zip Code

The Officer designated as agent of the **Insured Entity** and of all **Insureds** to receive any and all notices from the **Insurer** or their authorized representatives concerning this insurance:

Name Title E-mail Address

General Information (Provide details to all "Yes" answers by attachment)

1. Form of organization: Corporation Sole Proprietorship Joint Venture
 Partnership Limited Liability Corporation Other: _____
2. The **Named Insured** has been in continuous operation since: _____
3. What is the **Named Insured's** Federal Employer Identification Number (FEIN) or Taxpayer Identification Number: _____
4. (a) What is the **Insured Entity's** Primary Standard Industry Code (SIC): _____
 (b) Describe the **Insured Entity's** nature of operations: _____
5. (a) Within the last 12 months, has the **Insured Entity** been involved in any bankruptcy proceeding? Yes No
 (b) Within the next 12 months, is the **Insured Entity** contemplating filing a petition for protection under the bankruptcy code? Yes No
6. (a) Within the last 12 months, has the **Insured Entity** had any **Subsidiary**, plant, facility, branch or office closings, consolidations or layoffs? Yes No
 (b) Within the next 24 months, does the **Insured Entity** anticipate any **Subsidiary**, plant, facility, branch or office closings, consolidations or layoffs? Yes No

If "Yes", provide the following details by attachment: Date of event; number of **Employees** affected; whether outside employment counsel was consulted; and, whether severance packages were offered to all **Employees** affected.

Current Employee Information (Provide details to all "Yes" answers by attachment)

7. (a) Number of **Employees**: Do not include Leased **Employees** or Independent Contractors in numbers below.

	Full Time	Part Time	Seasonal	Temporary
Current Year:				
Prior Year:				
- (b) How many Leased **Employees** does the **Insured Entity** employ annually? _____
- (c) How many Independent Contractors does the **Insured Entity** employ annually? _____
- (d) What is the **Insured Entity's** annual employee turnover rate for the last 12 months? _____ %
8. Within the last 12 months, has there been any change (resignations, departures, retirements, etc.) in the position of the Chairman of the Board, President, Chief Executive Officer or Chief Financial Officer? Yes No
 "If "Yes", provide the following details by attachment: Name of individual and date of change.
9. What percentage of the **Insured Entity's** employees currently earns more than \$75,000? _____ %

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10. Does the **Insured Entity** (provide details to "No" answers by attachment):
- (a) Currently employ a full time Human Resources professional? Yes No
 - (b) Utilize employment applications for all prospective **Employees**? Yes No
 - (c) Require the Human Resource Department to review and approve each proposed **Employee** termination? Yes No
 - (d) Have outside employment counsel review each proposed **Employee** termination? Yes No
 - (e) Conduct mandatory periodic **Employee** education regarding prohibited forms of harassment? Yes No
 - (f) Periodically have its employment policies and procedures reviewed by outside employment counsel? Yes No
 - (g) Periodically have its employment policies and procedures distributed to all **Employees**? Yes No
11. Indicate which formal written policies and procedures have been implemented and attach a copy of each. None
If "None", so state.
- | | | |
|---|---|---|
| <input type="checkbox"/> Employee Handbook / Manual | <input type="checkbox"/> Anti-Harassment Policy, including Sexual Harassment | <input type="checkbox"/> <u>Employers with more than 50 Employees</u> |
| <input type="checkbox"/> Anti-Discrimination Policy – Equal Employment Opportunity (EEO) Policy | <input type="checkbox"/> Adherence to Employment "at-will" relationship with all Employees | <input type="checkbox"/> Family Medical Leave Act
<input type="checkbox"/> <u>California Employers Only</u>
<input type="checkbox"/> California Family Rights Act |

Litigation and Claim Information (Provide details to all "Yes" answers by attachment)

12. During the last 5 years, has the **Insured Entity** or any of its directors, officers or **Employees** known of, or been involved in any lawsuit, charges, inquiries, investigations, grievances or other administrative hearings or proceedings before any of the following agencies and/or in any of the following forums, including both domestic or foreign equivalents?
- (a) National Labor Relations Board? Yes No
 - (b) Equal Employment Opportunity Commission? Yes No
 - (c) Office of Federal Contract Compliance Programs? Yes No
 - (d) U.S. Department of Labor? Yes No
 - (e) Any state or local government agency such as the Labor Department or fair employment agency? Yes No
 - (f) U.S. District or state court? Yes No
13. During the last 5 years, has any current or former **Employee** or third party made any **Claim**, or otherwise alleged discrimination, harassment, wrongful discharge and/or **Wrongful Employment Acts** against the **Insured Entity** or its directors, officers or **Employees**? Yes No
- A **Claim** is not limited to the filing of a lawsuit or complaint with the Equal Employment Opportunity Commission or similar state or local agency. A **Claim** may also include a written demand or threat by any current or former **Employee** seeking relief in connection with an employment-related dispute or grievance.
14. Is the **Insured Entity** or its management aware of any fact, circumstance or situation involving any **Insureds** that he or she has reason to believe might result in a **Claim**, including, but not limited to, situations involving:
- (a) Threats by any current or former **Employee** or third party to take legal or other action against the **Insured Entity** or any of its **Employees**, or a demand or request by any current or former **Employee** for monetary or non-monetary relief, arising out of any alleged discrimination, harassment, wrongful termination, constructive discharge, or other **Wrongful Employment Acts**? Yes No
 - (b) Knowledge that any current or former **Employee** is engaging in, or has engaged in, acts of discrimination, harassment, or other **Wrongful Employment Acts**? Yes No
 - (c) Complaints or accusations by other **Employees** or third parties that a current or former **Employee** is engaging in, or has engaged in, acts of discrimination, harassment, or other **Wrongful Employment Acts**? Yes No
 - (d) Warnings, reprimands, or other disciplinary measures taken against any current or former **Employee** for acts of discrimination, harassment, or other **Wrongful Employment Acts**? Yes No

IF "YES" TO ANY PART OF QUESTIONS 12., 13., OR 14., PROVIDE FULL DETAILS FOR EACH ALLEGATION, EVEN IF THE MATTER HAS SINCE BEEN SETTLED OR OTHERWISE RESOLVED, BY COMPLETING A CLAIM SUPPLEMENTAL FORM EPL 4610 OR, BY PROVIDING THE FOLLOWING INFORMATION FOR EACH ALLEGATION BY ATTACHMENT:

- | | | | |
|----------------------------------|--|---------------------|--------------------|
| (a) Date Claim first made | (b) Claimant's Name | (c) Allegation | (d) Current Status |
| (e) Demand Amount | (f) Settlement (Indemnity) or Reserve Amount | (g) Attorney's fees | |

IT IS UNDERSTOOD AND AGREED THAT THE INSURER SHALL NOT BE LIABLE TO MAKE ANY PAYMENT FOR LOSS IN CONNECTION WITH ANY CLAIM MADE AGAINST ANY INSURED BASED UPON, ARISING OUT OF, DIRECTLY OR INDIRECTLY RESULTING FROM OR IN CONSEQUENCE OF, OR IN ANY WAY INVOLVING ANY LAWSUIT, ADMINISTRATIVE PROCEEDING, WRITTEN DEMAND, FACT, CIRCUMSTANCE, OR SITUATION SET FORTH OR THAT SHOULD HAVE BEEN SET FORTH IN THE INSURED'S RESPONSE TO QUESTIONS 12., 13., OR 14.

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Previous Insurance Information (Provide details to all "Yes" answers by attachment)

15. Provide the following information regarding the **Insured Entity's** Employment Practices Liability insurance for the current policy year. If "None", so state. None
- | | | | | |
|-------------------|-----------------|--------------------|------------|---------|
| Insurance Carrier | Expiration Date | Limit of Liability | Retentions | Premium |
| | | \$ | \$ | \$ |
16. Has the Extended Reporting Period (or Discovery Period) been exercised for the **Insured Entity's** most recent Employment Practices Liability Policy? Yes No

Documents Required

17. Provide details to all "Yes" answers, when applicable, by attachment
18. Provide the following information on all **Subsidiaries** of the **Insured Entity**. If "None", so state. None
- | | | |
|----------------------------------|--|-------------------------|
| (a) Name | (c) Percent of ownership | (d) Nature of business |
| (b) Date of acquisition/creation | (if less than 100 percent, list minority owners) | (e) Domestic or foreign |
19. Provide the following information on all plants, facilities, branches or offices of the **Insured Entity**. If "None", so state. None
- | | | |
|--------------|-------------------------|--|
| (a) Location | (b) Domestic or foreign | (c) Estimated number of Employees |
|--------------|-------------------------|--|

IT IS UNDERSTOOD AND AGREED THAT COVERAGE IS NOT PROVIDED FOR SUBSIDIARIES IN QUESTION 18. UNLESS THE INFORMATION REQUESTED ABOVE IS PROVIDED BY ATTACHMENT. ALSO, PROVIDE DETAILS TO QUESTION 19. BY ATTACHMENT, AS APPROPRIATE.

Please Read Carefully

The undersigned, acting on behalf of all **Insureds**, declare that the statements set forth herein are true and correct and that thorough efforts have been made to obtain sufficient information from each and every **Insured** proposed for this insurance to facilitate the proper and accurate completion of this Proposal Form.

The undersigned agree that the particulars and statements contained in the Proposal Form and any material submitted herewith are their representations and that they are material and are the basis of the insurance contract. The undersigned further agree that the Proposal Form and any material submitted herewith shall be considered attached to and a part of the Policy. Any material submitted with the Proposal Form shall be maintained on file (either electronically or paper) with the **Insurer** and shall be deemed to be attached hereto as if physically attached.

It is further agreed that:

- if any significant change in the condition of the applicant is discovered between the date of this Proposal Form and the Policy inception date, which would render this Proposal Form inaccurate or incomplete, notice of such change will be reported in writing to the **Insurer** immediately;
- any Policy, if issued, will be in reliance upon the truth of such representations; provided, however, with respect to such statements and representations, no knowledge or information possessed by any **Insureds**, except for those person or persons who executed the Proposal Form, shall be imputed to any other **Insureds** and further provided that if any person who executed the Proposal Form knew that such statement or representation was inaccurate or incomplete, then this Policy will be void as to all **Insureds**;
- this Proposal Form has been completed as respects the entire **Insured Entity**;
- the signing of this Proposal Form does not bind the undersigned to purchase the insurance.

	Title:
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Chairman of the Board of Directors, President, or Chief Executive Officer

	Dated:
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Print Name and Title

	Dated:
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Human Resources Manager (or equivalent position)

This Admiral Insurance Company Proposal Form, including any material submitted herewith, shall be held in strictest confidence.

A POLICY CANNOT BE ISSUED UNLESS THE PROPOSAL FORM IS PROPERLY SIGNED AND DATED.

Please submit this Proposal Form including appropriate documentation to:

Monitor Liability Managers, Inc., 2850 West Golf Road, Suite 800, Rolling Meadows, IL 60008-4039

	Dated:
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Submitted by (PRODUCER)

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AGENT'S NAME (Print Name)

AGENT'S LICENSE NUMBER

Admiral Insurance Company

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO NEW MEXICO, PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO APPLICANTS OF KENTUCKY: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUDS OR DECEIVES ANY INSURER OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, IS GUILTY OF A CRIME AND IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO APPLICANTS OF FLORIDA, MINNESOTA, NEW JERSEY, OHIO, AND OKLAHOMA: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUDS OR DECEIVES ANY INSURER OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, IS GUILTY OF A FELONY AND IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO DISTRICT OF COLUMBIA, MAINE, MASSACHUSETTS AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.